# Multi-Payer Workgroup

## Multi-Payer Workgroup Proposal

The IHC Multi-Payer Workgroup, under the direction of the IHC, and through collaboration across payers and providers, has worked on a plan to transform payment methodology from volume to performance based value. The Multi-Payer Workgroup backs a phased-in system of payment transformation that supports primary care practices in maintaining an infrastructure as a Patient Centered Medical Home through transition to a payment system based on outcomes

The Scope of the Multi-Payer workgroup included:

1. Transition to incentivizing performance based value as opposed to volume by transforming payment mechanisms across payers.
2. Address parameters for the payers' patient attribution, population risk/stratification methodology upon which the payers will build their payment amounts.
3. Determine appropriate payment methodologies using a phased in approach:

The following items were out of scope for IHC Multi-Payer workgroup, and therefore they were not addressed:

1. Startup costs for transformation and accreditation which is funded through the IHC grant
2. Negotiating specific contract reimbursement terms. Each payer will do this directly through their regular contract negotiation process

The Multi-Payer workgroup supports multiple payment models that adapt to each practices current level of transformation readiness. The attached Idaho Multi-Payer Payment Transformation Summary provides information from participating workgroup members.

# Idaho Multi-Payer Payment Transformation Summary

## MEDICAID

**PMPM:** Tiered System

**Other Incentive:**
Future plans to allow payments for quality outcomes and shared savings.

**DX Qualifications:**
One tier for basic management with a higher PMPM for chronically ill patients. Advanced tiers for different levels of PCMH transformation.

**Member Tools:** None at this time

**Provider Tools:**
- ER reports,
- Quality reports
- cost of care reports

**Present or Future PCMH Plans:**
Current plan and future plans to enhance the PCMH clinics in Medicaid.

**Communication to Interested Provider:**
Medicaid will support clinics transforming to the PCMH by implementing a tiered, risk stratified PMPM approach to include Quality measures that align with the SHIP.

## MEDICARE

**PMPM:** Chronic care management (CCM) services fee PMPM for participating Medicare FFS clients

**Other Incentive:** PQRS with migration as per MACRA to MIPS in 2018

**DX Qualifications:** CCM services - 2 or more chronic conditions expected to last at least 12 months and that place the patient at significant risk of functional decline, acute exacerbation or death

**Member Tools:** Requires patient consent and designation of one practice/physician who is eligible for CCM payments

**Provider Tools:** Requires a care plan, structured data recording, access to care, management of care , and use of certified EHR

**Present or Future PCMH Plans:** Presently available to physicians and certain non-physicians for patients who opt-in for services. SHIP to explore possible alterations as part of Medicare Alignment request

**Communication to Interested Provider:** Chronic Care Management Services Fact Sheet from CMS Medicare Learning Network. www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf

## BLUE CROSS

**PMPM:** Yes

**Other Incentive:**
Value Based Payments

**DX Qualifications:**
● Diabetes ● Asthma ● Congestive Heart Failure

**Member Tools:** Transparent tools

**Provider Tools:**

**Present or Future PCMH Plans:**
They have the current PCMH program and have future plans to continue and add more PCMH practices
Expand initiatives with specific provider groups that have the financial ability as well as a demonstrated track record of practice transformation to move from fee-for-service payments to capitated payments where a PCP can be assigned with certainty.

**Communication to Interested Provider:**
The value-based fee schedule structure, using the Truven cost-efficiency system, will be the major incentive option for the most practices during 2016.

## PACIFICSOURCE

**PMPM:** Yes, or lump sum payment towards clinical initiative

**Other Incentive:** Value Based Payments, and Community Health Excellence Grant Program

**DX Qualifications:** No dx restrictions at this time, but potentially in the future.

**Member Tools:** Treatment Cost Estimator on Member Portal, Courtesy Calls for: Medication Adherence, Health Screenings, and Post-Hospital Discharge

**Provider Tools:** Pharmacy Reports, Quality Measures Reports, Cost & Utilization Reports, Complex Member Reports (ER, IP, Risk Score, etc), and Provider Partnership Liason.

**Present or Future PCMH Plans:**
Present: Various models; provide enough flexibility in payment models to support the providers' different capabilities and the needs of the community. Current PCMH – Decrease FFS, PMPM, Incentives for Quality. Other models for other levels include upside only incentive programs, grant program, capitation models.
Future: Keep expanding on current programs

**Communication to Interested Provider:**
PacificSource supports a variety of Alternative Payment Models that adapt to each practices current level of transformation readiness. These models may include decreased Fee for Service Payment, PMPM incentive payments or other clinical investment, and the use of established performance metrics tied to incentives. PacificSource's primary care partnerships must meet minimum membership thresholds to be considered for a contract based on alternative payment methodologies.
Contact Hilary.klarc@pacificsource.com for specific inquiries or more information

## REGENCE

**PMPM:** No

**Other Incentive:**
ACO 1.0 "Total Cost of Care." PPO network. Gainshare only, moving to ACO with financial risk. Management of Cost trend target and 16 quality metrics generates shared savings. Program pairs with physician groups or IPAs; minimum attribution 1000 members.

**DX Qualifications:** None

**Member Tools:**

**Provider Tools:**
Full cost transparency on attributed members. Lumeris provided as analytics software for cost and quality. Ongoing support by team of analysts to identify cost drivers.

**Present or Future PCMH Plans:**
Gainshare, moving to full risk and full delegation within 2-3 years.

**Communication to Interested Provider:**
Value-based reimbursement, which includes TCC for physicians, P 4 P on hospitals, and quality-based reimbursement schedules for ancillary providers.

## SELECTHEALTH

**PMPM:** Yes

**Other Incentive:** Pay-for-Performance

**DX Qualifications:** No diagnosis restrictions. All Selecthealth patients seen in the practice are included in a PMPM. Evaluating opportunities to shift to a methodology that includes a risk adjustment.

**Member Tools:**

**Provider Tools:**
Reporting: Online reporting for quality performance and gaps in care.
Selecthealth medial home liaison to provide ongoing program support.

**Present or Future PCMH Plans:**
No current Idaho program. They are looking into future Idaho implementation.

**Communication to Interested Provider:**
Selecthealth is supportive of the medical home model and there is interest in adding Idaho practices to the program once sufficient membership volume is achieved to support pay-for-performance payments.

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